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ABSTRACT

As a result of a survey of 2,322 Houston adults, a nine-phase methodology was used to design a program of public education about cardiovascular disease (CVD). Survey results indicated that Mexican Americans were significantly less knowledgeable than Anglos concerning the impact, nature, and control of CVD. Many Mexican Americans could not recognize CVD as the major cause of death in the United States, define "arteriosclerosis," identify CVD risk factors, or identify the warning signals of a heart attack. Many Mexican Americans did not perceive CVD as a personal health threat nor feel they could control their own health. However, Mexican Americans and Anglos reported similar health care practices. Many respondents relied on mass media for health information but considered doctors a more accurate source. The resulting community health information program of television public service announcements was intended to increase awareness of and response to CVD by Houston's Mexican Americans. Applicable to other health programs, the methodology used to design the program involved identifying the target audience, identifying program goals and objectives, conducting fact-finding research with focus groups, selecting the media, designing pre- and post-program evaluations, implementing the program, evaluating the program, comparing evaluation results, and revising the program. ("El Asesino Silencioso" translates as "The Silent Killer.") (SB)

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El Asesino Silencioso: A Methodology for Alerting the Spanish Speaking Community

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El Asesino Silencioso: A Methodology for Alerting the Spanish Speaking Community

Information on the health status of the Spanish heritage population, the nation's second largest minority, is extremely scarce. In particular, few studies have attempted to document the prevalence of hypertension or other cardiovascular diseases in this minority population. However, before any large scale interventions to determine the prevalence of hypertension is initiated, preliminary questions concerning how to reach and motivate the Spanish speaking population to adopt risk-reducing cardiovascular health behaviors must be answered.

In order for effective health information and/or education programs to be developed in the area of cardiovascular disease (CVD) a better understanding of the target population's mechanisms of communications, motivation and modification of behavior are urgently needed. Any attempt to communicate with a specific target audience with respect to CVD must also take into consideration a complete understanding of the intended receiver's existing health knowledge, attitudes, and practices, as well as their socio-cultural background, needs and interest.

One approach that we utilized to obtain this type of information was through a community survey which was conducted in Houston, Texas by Baylor College of Medicine's Public Education Section. The purpose of the community survey was to establish a data base for Baylor's National Heart Center. This data base would allow us to design future health education programs for the Houston community. Through the community survey we were able to determine the existing knowledge, attitudes and practices related to CVD and its associated risk factors, as well as the media habits of Houston area adults, 18 years of age and older. The primary random sample is comprised of 2,322 Houston residents with appropriate proportional representation of the ethnic composition of the survey area (69% Anglo, N=1,605, 23% Black, N=547, and 8% Mexican American, N=170).

The survey results revealed that a serious lack of even the most basic knowledge regarding heart disease exists in several adult sub-populations in the Houston community. In particular, a comparison of ethnic profiles drawn from the random survey respondents revealed that, in general, the Spanish or Mexican American population was significantly less knowledgeable concerning the impact, nature and control of CVD than the Anglo population with which it is generally combined. For example, 56.3% of the Anglo respondents recognized CVD as the major cause of death in the United States whereas only 32.3% of the Mexican American correctly cited heart disease as the number one killer. Compared to 73.7% of the Anglo population, only 35.2% of the Mexican Americans surveyed had ever heard of the word "arteriosclerosis," which describes the major biological process associated with CVD. When provided with a list of possible definitions for this word, only 34.1% of the Mexican Americans could select a correct definition, compared to 72.8% of the Anglo respondents. The most common correct definition of arteriosclerosis was "hardening of the arteries" which was selected by 45.0% of the Anglo respondents compared to only 17.3% of the Mexican American respondents. Another common definition which was selected with more frequency was "clogging of the blood vessels." This response was selected by 24.7% of the Mexican America respondents and by 48.1% of the Anglo respondents.

When asked to identify the six behavioral habits or characteristics associated with increased risk of CVD, 78.8% of the Anglos surveyed correctly named more than two of these risk factors with the highest percentage of respondents naming three. In contrast, only 54.8% of the Mexicans named two or more of these risk factors, with the highest percentage of respondents naming only 1 or 2 factors. Of particular interest is the fact that hypertension was cited by only 13.9% of the Mexican American, versus 22.2% of the Anglo respondents. Finally, only one-third of the Mexican Americans could name one or more of the warning signals of a heart attack compared to slightly more than half of the Anglo respondents.

In general, however, the community survey data related to CVD health knowledge clearly revealed that a substantial portion of the Mexican American community does not even possess the fundamental knowledge prerequisite to begin adopting risk-reducing behaviors.

In assessing attitudes toward CVD, only 32.3% of the Mexican American respondents cited heart disease as the health problem about which they were most concerned, compared to 42.6% of the Anglo population. In determing the respondents likelihood of ever having a heart attack, 43.6% of the Anglo respondents perceived that they were "likely" or "very likely" to suffer a heart attack, while only 34.7% of the Mexican Americans had a comparable perception to this health threat. Both the Anglo (62.6%) and the Mexican American (60.6%) respondents felt that it was "very important" to reduce their risk of CVD, however, only 55.9% of the Mexican Americans compared to 74.2% of the Anglos, felt that they could control their health "a great deal" through their own actions. These data point out that the Mexican American has a relatively low sense of vulnerability and self-fatalism with respect to CVD. Although the majority of both Mexican American and Anglo respondents felt that it was important to reduce their risk of heart disease, the Mexican Americans' significant lack of knowledge as to how to accomplish this would prevent any positive health behavior change.

In contrast to differences in knowledge and attitudes noted between the Mexican American and Anglo respondents, reported health care practices were quite similar. Approximately two-thirds of the Mexican American and Anglo respondents reported having a physical check-up at least once a year. An even greater percentage, 80.6% of the Mexican Americans and 84.3% of the Anglos, reported having their blood pressure checked within the last year. While on the surface, these results are impressive, further analysis underscored the fact that regular medical visits, in this case for blood pressure checks, were not necessarily correlated with increased knowledge as 62.8% of the Mexican Americans surveyed, compared with 45.6% of the Anglos, were not told what their blood pressure was. The majority of the respondents,

88.4% of the Anglos and 75.1% of the Mexican Americans, indicated that they receive their regular health care from their doctor. However, Mexican Americans tend to rely more heavily than Anglos on public health clinics for health services.

Although the health practices reported by the Mexican American respondents are encouraging, their low knowledge level and misconceptions of CVD indicate that they are not obtaining adequate preventive health information from their physicians or clinic personnel and underscore the need to supplement these information sources with other channels.

Already certain auxiliary channels play an important role in disseminating health information.while only 22.0% and 35.5% of the Anglo and Mexican American respondents respectively cited their doctor as their primary source of health information, 59.5% and 47.0% respectively of these populations cited some form of mass media (ie. television, radio, newspapers, and magazines) as the primary source of such information. Television, cited by 24.7% of the Mexican American respondents, ranked highest among mass media sources followed by newspaper at 13.8%. These results are in contrast to the Anglo responses. Although both groups cited heavy reliance on mass media for health information, the credibility associated to these sources is relatively low. As noted on this table 72.9% of the Anglo and 74.6% of the Mexican American populations cited doctor as the most accurate source of health information, all forms of mass media were cited by 21.4% of the Anglos and 17.8% of the Mexican Americans. Of all mass media, magazines were cited as having the greatest credibility in the health information area, for both ethnic groups. Television followed as the second most accurate source of health information in this category.

Respondents were also questioned about the utilization of special media, such as brochures and pamphlets, as sources of health information. Fifty point six percent of the Mexican American and 43.4% of the Anglo respondents reported that they picked up free health brochures. In focusing on what factors would increase

their willingness to read such special brochures, more than three-fourths (86.1% Anglo, 80.6% Mexican American) of the Mexican American and Anglo respondents cited that receiving such information from their doctor, or other credible health agencies such as the American Heart Association, in mail addressed to them would increase their willingness to read it. The survey data indicated that the potential of the mass media in health education may, perhaps, be actualized through an effective linkage between mass media impact and medical authority credibility.

Based on the survey results, we designed a community health Information Program, which I will refer to as "CHIP", in accordance to the Public Education Section's research methodology. The overall aim of the program was to demonstrate the effectiveness of the systematic utilization of appropriate methods and media to stimulate increase awareness of, and behavioral response to, the problem of high blood pressure by a specific target audience.

As I continue my presentation I will be describing the methodological approach that we utilized to design our program. This approach can also be utilized for other health programs.

First of all, we identified our target audience. We selected the Mexican American population in Houston because of this group's need for preventive health information on CVD as documented by the Community Survey results and the need for additional studies to further document the health status and behavior of this ethnic group.

The Community survey results provided us with a foundation upon which to develop a systematic health educcation program based upon known rather than assumed audience needs, characteristics, and media utilization patterns.

After we defined our target audience, we identified the program goals and objectives.

The primary goal of the program was to develop and evaluate a replicable communications model designed to increase awareness of, and behavioral response to, the problem of high blood pressure among Houston's Mexican American population. Specific objectives included:

1. Determining message content based upon the target audience's knowledge, attitudes and practices related to CVD and its associated risk factors, particularly high blood pressure.
2. Determine message language and appropriate motivational appeals via focus groups conducted with representatives of the defined target audience.
3. Disseminate messages in accordance with documented media habits of the target population.

The third phase of our methodology consists of conducting additional fact-finding research to determine message appeal and appropriate media selection for disseminating the messages to the target audience. Our research and fact finding consisted of two focus group sessions with representatives from the target population. A focus group is an informal session in which several participants are asked to discuss in their own words all aspects of a specified topic or subject matter. The discussions are monitored by one or more professionals and the entire session is taped for more in-depth review. Such groups are designed to gain more insight and understanding of the target audience's "frame of reference" about a specific topic.

The focus groups input is instrumental in clarifying subjective areas such as appropriate language and culturally relevant appeals. When this data is coupled with the objective data from our survey, this information provided us with a more comprehensive picture of the intended audience. The sessions are also analyzed for terminology, expressions and other verbal communications that may surface. This information provides useful guidelines for program and message design.

The two focus group sessions were conducted in Spanish. The format for the sessions was pre determined and consisted of a series of questions designed to determine appropriate message content, media, and evaluation procedures. The participants also viewed a series of health-related television public service announcements that illustrated various media appeals (ie. testimonial fear arousel, endorsement). The participants were asked to react and comment on each of the spots.

With respect to the message, focus group results underscored the importance of cultural relevancy in both language and content. Specifically, the focus group participants stated that the messages should be in Spanish and focus on the Mexican Americans' concern for self and family. The importance of both audience identification and perceived vulnerability emphasized the need to incorporate some element of fear in the messages. The participants reported media habits which correspondded with those documented in the community survey and emphasied the importance of the loral minority T. V. station.

When questioned about requesting additional health information, the participants suggested calling a specific telephone number because this would provide an easy and immediate channel for feedback. However, they did specify that a bilingual person should answer the telephone requests and that the information provided should be free of charge.

Phase IV of the methodology is Media Selection. Based on the survey and focus group results television was selected as the most appropriate media for the awareness stage of the program. The use of broadcast public service announcements or PSAs were selected for disseminating the message. The flexibility and adaptability to low-cost production techniques made this format popular. However, time constraints inherent in the PSA format severly limit the scope of the message content. Therefore, the messages we designed focused on making the audience aware of the problem and providing them with an avenue for action.

In the CHIP program the avenue for action was provided by a telephone feedback channel by which the audience memebers could obtain free information which outlined behavioral steps required to protect themselves against hypertension. A special medium, in form of a bilingual (Spanish and English) printed brochure, was chosen to provide this information upon which the target respondents could base further descision-making in adopting preventive behaviors. Unlike broadcast media, this printed format is more ideally suited to the presentation of detailed factual information concerning hypertension, or any other health problem, and explicit instructions concerning appropriate action to control it. The brochure stressed that the first step toward detection or control of hypertension is a blood pressure check. Therefore, incorporated in the brochure was a list of health facilities that would provide a free blood pressure check and if needed additional medical care.

The evaluation component of the methodology is one of our most important steps because it allows us to accurately assess the program's impact. CHIP's penetration and effects, in terms of target population awareness of the PSAs and reported behavioral response, were measured through a separate sample pretest-posttest surveys implemented before and after the program's implementation.

The pre-program measurement was conducted to provide baseline data against which the effects of the mass media campaign could be gauged. Specifically this phase consisted of a random telephone survey of adults, 17 years-of-age and older, in 500 Harris County Mexican American households to determine target ponulation awareness of the problem of high blood pressure, sources of awareness and relevant health behaviors.

After the six-week campaign was completed, an identical post-measure was conducted with a separate random sample of 500 Mexican Americans telephone households. This measure allowed us to assess market penetration of the televsion PSA Campaign and consequent effects.

Program Implementation is the next phase. CHIP was produced and implemented over a six-month period. Planning for the program involved a comprehensive, budget, production and implementation schedule to ensure completion of the project by the designated deadline date. Based on the results of the target population research, three television PSAs were designed and produced in Spanish. A professional media consultant group, including television and radio PS directors and other mass media personnel representatives of the target population, was organized and convened periodically throughout the campaign design to guide the development of message content and format. This cooperative planning effort was designed not only to obtain program ideas but also to secure the active involvement of these key media gatekeepers in the initial planning stages to insure maximum media support, in terms of public service air time during the actual program implementation.

Incorporating information and ideas gleaned in both the mass media consultant and Mexican American focus groups, the concepts, scripts and storyboard for the 3 Spanish PSAs were developed by the Public Education Section staff.

Audio recordings of each script and detailed visual storyboards were developed and incorporated in a pretest with another Mexican American focus group. The purpose of the pretest session, which was conducted in Spanish, allowed us to determine the understandability of the language and messages; the appropriateness of the scenes and subject matter; and the selection of the telephone call-in response system. The results of the pretest were very positive and we only had to make minimal changes in the wording of the script. The final scripts and storyboards were also reviewed and endorsed by the media consultant group prior to production.

We recruited volunteer talent from a local Mexican American drama group for the characters in the spots and for the recording. The services of a professional cinematography firm was secured for the final film and videotape production of the spots.

The three PSAs were designed to maximize audience identification with, and involvement in, the message. A Mexican American announcer and actors were used in all the announcements to enchance source credibility. Based on both the lay and professional focus groups input, the messages were designed to increase the viewers' perceived vulnerability by drawing them into dramatic scenes in which the "silent killer" - high blood pressure - was lurking. The announcements were motivational, versus information, in nature. Specifically, the spots were designed to stimulate the audience to take a specific action, in our situation, calling for additional information to receive instructions concerning the control of high blood pressure. At the conclusion of each spot, explicit instructions were given to take this recommended action by showing the telephone number to call.

At the conclusion of my presentation I will show you the spots.

The respondents who telephone for more information were mailed a bilingual brochure on high blood pressure. Input from a final lay Mexican American focus group was obtained regarding the format of the brochure. For example if they liked the "Novela" - dramatized story format versus a more factual format. In addition, Mexican American professionals representing various health and education fields were recruited to serve as consultants in the development of the brochure. Their recommendations, coupled with the focus group and survey data, were incorporated into the brochure which described the dangers of high blood pressure, outlined the necessary steps for controlling this disease and provided a list of locations where a free blood pressure check could be obtained.

In light of the fact that no readability formulas could be located for Spanish texts, the Flesch and SMOG formulas were applied to the English version indicating that the brochure was on a sixth grade reading level. (86.5% MA reading level, 6th grade or above).

The campaign spots were aired for six weeks beginning in early January. This time was selected because of the post-holiday decline in commercial advertising which increased the availability of public service air time. The announcements were aired a total of 224 times during this period on all local television stations (one devoted evenings to Spanish programming).

A telephone line with two rotating numbers was installed and maintained throughout the campaign to provide a feedback channel for the population response. The telephone line was staffed 12 hours a day by bilingual interviewers who obtained the respondents' name and mailing addresses in order to send out the brochures.

After the campaign program was completed the post-evaluation was administered. And this brings us to the second to the last step in our methodology, which is results.

Comparison of the pre and post-campaign survey results revealed that over one third (35.6) of the target population surveyed (N=500) reported awareness of one or more of the campaign PSAs on television.

The levels of awareness varied among population sub-sets defined on the basis of selected demographic characteristics and experiences related to high blood pressure. Those who exhibits the highest level of awareness were males, individuals who received blood pressure checkups within the past year, and those who elected to take the evaluation survey in Spanish. My Collegue, Ms. Lee Herrick will be giving a poster presentation at the National High Blood Pressure Conference which will focus on the results of the program in more detail. Her presentation is scheduled for 2:15 tomorrow, so please drop by if you have any questions or if you'd like to see the program results in more detail.

Based on the data we obtained from the program evaluation, our spots did not require revisions which is the last item on our methodology. Infact, our spots have been adopted by the Texas American Heart Association for state-wide distribution and we have also received requests from the Seattle Heart Association for the English Version of our spots.

Now I would like to let you view our public service announcements.

PERCEIVED MAJOR CAUSE OF DEATH
BY ETHNICITY AND SEX OF RESPONDENT

Response	White M 576	White F 1028	White T 1604	Mexican American M 67	Mexican American F 103	Mexican American T 170	Total 1774
Heart Disease	55.9	56.6	56.3	38.8	28.2	32.3	54.1
Cancer	16.3	23.2	20.9	16.4	37.9	29.5	21.5
Accidents	19.3	13.7	15.8	26.9	14.5	19.4	16.1
Other	7.1	5.9	6.1	16.4	18.4	17.6	7.4
Don't Know	1.4	0.6	0.9	1.5	1.0	1.2	0.9
Total	109.0	100.0	100.0	100.0	100.0	100.0	100.0

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HEARD OF WORD ARTERIOSCLEROSIS BY ETHNICITY AND SEX OF RESPONDENT

	White			Mexican American			
	M	F	T	M	F	T	Total
Response	569	1011	1580	64	98	162	1742
Yes	72.2	74.6	73.7	29.7	38.8	35.2	70.2
No	27.8	25.4	26.3	70.3	61.2	64.8	29.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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MOST COMMON CORRECT RESPONSE TO ARTERIOSCLEROSIS
BY ETHNICITY AND SEX OF RESPONDENT

Response	White			Mexican American		
	M	F	T	M	F	T
	569	1011	1580	64	98	162
Hardening of the arteries	43.6	45.1	45.0	13.4	18.4	17.3
Clogging of blood vessels	46.4	49.4	48.1	16.4	28.2	24.7

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NUMBER OF HEART DISEASE RISK FACTORS
CORRECTLY IDENTIFIED BY ETHNICITY AND SEX OF RESPONDENT

No. of Risk Factors Identified	White M 576	White F 1028	White T 1604	Mexican American M 67	Mexican American F 103	Mexican American T 170	Total 1774
None	7.5	5.6	6.3	19.4	18.4	18.8	7.5
1	15.5	14.6	14.9	24.9	28.2	26.4	16.0
2	33.5	28.1	30.0	27.9	24.3	26.0	29.6
3	29.0	35.6	33.3	21.8	17.5	19.6	32.0
4	13.2	14.2	13.8	6.0	11.6	9.2	13.4
5	1.3	1.8	1.7	0.0	0.0	0.0	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Correct risk factors included: High blood pressure, high cholesterol (saturated fat) level, smoking, overweight, lack of exercise and stress (worry, tension).

Total sample: 53.1% could name no more than 2 risk factors.

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NUMBER OF WARNING SIGNS OF A HEART ATTACK
IDENTIFIED BY ETHNICITY AND SEX OF RESPONDENT

Number of Signs Identified	White			Mexican American			Total
	M	F	T	M	F	T	
	572	1028	1600	67	103	170	1770
None	53.0	45.4	48.2	70.1	65.0	67.0	50.4
1	41.0	49.4	46.5	29.9	34.0	32.4	44.6
2	6.0	5.2	5.3	0.0	1.0	0.6	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Warning signs included: Sharp pain in chest, sweating, shortness of breath, and radiating pain in neck, shoulder or arm.

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HEALTH PROBLEM MOST CONCERNED ABOUT BY ETHNICITY AND SEX OF RESPONDENT

Health Problem	White M 576	White F 1028	White T 1604	Mexican American M 67	Mexican American F 103	Mexican American T 170	Total 1774
Heart Disease	49.8	38.6	42.6	44.8	24.3	32.3	42.0
Cancer	26.2	36.2	32.6	22.4	45.6	36.5	33.0
Accidents	7.3	4.8	5.8	14.9	5.8	9.4	6.3
Other	14.8	19.7	17.9	16.4	24.3	21.2	18.0
Don't Know	1.9	0.7	1.1	1.5	0.0	0.6	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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LIKELIHOOD OF HAVING A HEART ATTACK
BY ETHNICITY AND DEX OF RESPONDENT

Response	White M 572	White F 1023	White T 1595	Mexican American M 67	Mexican American F 103	Mexican American T 170	Total 1765
Very likely, likely	45.9	42.4	43.6	35.8	34.0	34.7	41.4
Very unlikely, unlikely	34.9	40.2	38.4	30.0	34.0	32.3	37.8
Don't Know	19.2	17.4	18.0	34.2	32.0	33.0	20.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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IMPORTANCE OF REDUCING RISK OF PERSONALLY HAVING A HEART ATTACK BY ETHNICITY AND SEX OF RESPONDENT

Response	White			Mexican American			Total
	M	F	T	M	F	T	
	574	1026	1600	67	103	170	1770
Very important	58.0	65.3	62.6	52.2	66.1	60.6	62.4
Important	30.7	27.8	28.8	38.8	22.3	28.8	28.8
Unimportant	4.7	3.0	3.6	0.0	1.9	1.2	3.4
Very unimportant	4.0	1.9	2.8	1.5	2.9	2.3	2.6
Don't Know	2.6	2.0	2.2	7.5	6.8	7.1	2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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ABILITY TO CONTROL YOUR HEALTH THROUGH YOUR OWN ACTIONS BY ETHNICITY AND SEX OF RESPONDENT

Response	White M 574	White F 1023	White T 1597	Mexican American M 67	Mexican American F 103	Mexican American T 170	Total 1767
A great deal	68.3	78.0	74.5	44.8	63.1	55.9	72.7
Somewhat	28.4	19.6	22.8	32.8	25.2	28.2	23.3
Not at all	0.9	0.5	0.6	4.5	1.0	2.3	0.8
Don't Know	2.4	1.9	2.1	17.9	10.7	13.6	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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HEALTH CARE PRACTICES BY ETHNICITY AND SEX OF RESPONDENT

Response	White M	White F	White T	Mexican American M	Mexican American F	Mexican American T	Total
Physical Check-up at least once a year							
Yes	51.6	71.9	64.6	40.3	78.6	63.5	64.5
No	48.4	28.1	35.7	59.7	21.4	36.5	35.6
Last time BP* checked							
< 1 year	79.6	87.1	84.3	73.2	85.4	80.6	84.0
1 - 2 years	10.4	7.8	8.7	16.4	7.8	11.2	9.0
Told BP reading							
Yes	55.9	43.1	47.6	23.3	31.3	28.2	45.9
No	35.8	51.0	45.6	68.3	59.4	62.8	47.2
Location of regular health care							
Doctor	83.3	91.3	88.4	68.2	79.6	75.1	87.2
Hospital	5.7	2.6	3.7	10.6	4.9	7.1	4.0
Public clinic	7.4	5.9	6.4	12.1	17.5	15.4	7.3

* BP - Blood Pressure

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MAJOR SOURCE OF HEALTH INFORMATION IDENTIFIED
BY ETHNICITY OF RESPONDENT

Response	White N = 1584 Adjusted %	Mexican American N = 166 Adjusted %	Total N = 1650 Adjusted %
Doctor	22.0	35.5	24.7
Newspaper	28.0	13.8	28.4
Magazines	12.2	4.8	12.2
Television	16.2	24.7	18.1
Radio	3.0	3.6	3.2
All other sources and don't know response	18.6	17.6	13.4
Total	100.0	100.0	100.0
* Mass Media	59.5	47.0	61.8

* Mass Media: Television, radio, newspaper, magazines

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MOST ACCURATE SOURCES OF HEALTH INFORMATION
IDENTIFIED BY ETHNICITY OF RESPONDENT

Response	White N = 1497 Adjusted %	Mexican American N = 146 Adjusted %	Total N = 1643 Adjusted %
Doctor	72.9	74.6	73.0
Mass Media	21.4	17.8	20.9
Books	2.9	2.7	2.9
All other responses	2.7	4.1	3.0
Don't Know	0.1	0.8	0.2
Total	100.0	100.0	100.0

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METHODOLOGY

Public Education Section
National Heart and Blood Vessel
Research and Demonstration Center
Baylor College of Medicine

I. Define Target Population(s)

II. Determine Program Goals

III. Define Program Objectives

IV. Conduct Research / Fact Finding

V. Determine Theme / Appeal

VI. Select Media
   A. Mass Media
   B. Special Media
   C. Interpersonal Channels

VII. Design Evaluation Procedure

VIII. Implement Program
- A. Detailed Production and Implementation Schedule
- B. Budget
- C. Pre-Test
- D. Pilot-Test
- E. Revision

IX. Conduct Program Evaluation
   A. Technical Evaluation
   B. Program Evaluation

X. Report Results

XI. Revise Program (if needed)